**Fall Risk Screen**

**Fall History**

Any falls in past year? [ ] Yes [ ] No

Worries about falling or feels unsteady when standing or walking? [ ] Yes [ ] No **Medical Conditions**

Problems with heart rate a/o arrhythmia? [ ] Yes [ ] No

Cognitive impairment? [ ]Yes [ ] No

Incontinence? [ ] Yes [ ] No

Depression? [ ] Yes [ ] No

Foot problems? [ ] Yes [ ] No

Other medical problems? [ ] Yes [ ] No

**Medications (prescriptions, OTC, supplements)**

Psychoactive medications? [ ] Yes [ ] No

Opioids? [ ] Yes [ ] No **Strength and Balance**

Balance Assessment? Score indicates risk [ ] Yes [ ] No

**Vision**

Acuity <20/40 OR no eye exam in >1yr [ ] Yes [ ] No

**Postural Hypotension**

Decrease in systolic BP >20mmHg or diastolic >10mmHg [ ] Yes [ ] No **Other risk factors**

Specify here\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If the patient/caregiver answers YES to any of these questions, an Occupational Therapy Evaluation is recommended. A licensed Occupational Therapist will perform an in-depth assessment.**

Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_